| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218 |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |   | (X3) DATE SURVEY COMPLETED 03/03/2011 |                            |
|--|--|---|--|---------------------|---|---------------------------------------|----------------------------|
|  | PROVIDER OR SUPPLIER   |   |  | 2300 G              | ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311   | 1                                     |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | .ΤΕ                                   | (X5)<br>COMPLETION<br>DATE |
| F0000  | This visit was for Complaint IN000 This visit was in Survey Revisit (I IN00083771 involuments) This visit was in Survey Revisit (I IN00084299 involuments) Complaint IN000 federal/state definallegations are cited. | r the Investigation of 085845.  conjunction with a Post PSR) to Complaint estigated on 12/28/10.  conjunction with a Post PSR) to Complaint estigated on 1/19/11.  085845 substantiated, ciency related to the sted at F 224.  encies cited.  larch 2 and 3, 2011  000123  155218  00266720  N, TC  N | F00  |                     | The facility requests that this of correction be considered its credible allegation of complian Preparation and/or execution this plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because is required. | plan<br>s<br>nce.<br>of<br>ot<br>the  | DATE                       |
|  | Census payor typ   | oe:   |  |                     |   |                                       |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 000123 If continuation sheet

TITLE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155218 |   |   | (X2) MULTIPLE CO  A. BUILDING  B. WING | COMI  | (X3) DATE SURVEY  COMPLETED  03/03/2011 |                            |
|--|---|---|--|---|---|----------------------------|
|  | PROVIDER OR SUPPLIER  |   | STREET A<br>2300 G                     | ADDRESS, CITY, STATE, ZIP COD<br>REAT LAKES DRIVE<br>IN46311  | DE                                      |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | JLD BE                                  | (X5)<br>COMPLETION<br>DATE |
|  | Medicare: 33 Medicaid: 90 Other: 19 Total: 142 Sample: 15 These deficiencie | es also reflect State dance with 410 IAC 16.2.                                    | 1                                      | CROSS-REFERENCED TO THE APP   | ROPRIATE                                |                            |
|  |   |   |  |   |   |                            |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155218 03/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2300 GREAT LAKES DRIVE REGENCY PLACE OF DYER DYER. IN46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0224 Based on record review and interview the F0224 03/21/2011 F - 224facility failed to ensure residents were free SS=G It is the practice of this facility to from neglect for 1 of 1 residents reviewed ensure the highest quality of care with percutaneous endoscopic is afforded our residents. Consistent with this practice, the gastrostomy tube (peg tube, a tube used following has been done: The for nutritional purposes) in a sample of 14 corrective action taken for the related to a nurses not flushing the residents found to have been resident's peg tube prior to administering affected by the deficient practice medications resulting in the peg tube was: Resident G's PEG tube was flushed at the time of survey. The become clogged and the resident going to licensed nurse responsible has the hospital to have the peg tube replaced. been counseled/terminated. The (Resident #G) corrective action taken for those residents having the potential to be affected by the same deficient Findings include: practice is: All residents of the nursing center with enteral The record for Resident #G was reviewed feeding tubes have the potential on 3/3/11 at 7:35 a.m. The resident's to be affected, therefore, this plan of correction applies to all diagnoses included, but was not limited residents with enteral feeding to, cerebral vascular accident (CVA, tubes. The measures put into Stroke) and dysphasia (impairment of place and systemic change made speech). to ensure the deficient practice does not recur is: Licensed nursing staff has been in-serviced A nursing note dated 2/18/11 at 8:00 a.m., related to care of enteral feeding indicated the resident was in bed asleep, tubes, including but not limited to unable to flush g-tube (gastrostomy tube, proper technique for checking tube used for nutritional purposes). The placement and water flushes according to physician order. resident's feeding had clogged the tube. Licensed nurses will complete a Several attempts were made without competency check off with return success to unclog the tube. Bowel sounds demonstration to ensure proper technique. The Staff were present in four abdominal quadrants. Development Coordinator, or There was no tenderness noted. No facial designee, shall observe enteral grimaces at this time. At 8:30 a.m. the feeding tube procedures for at Nurse Practitioner was notified. An order least 2 residents daily, on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G8L511

Facility ID:

000123

If continuation sheet

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| STATEMEN  | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M  | ULTIPLE CO | NSTRUCTION  | (X3) DATE SURVEY |           |
|-----------|---|------------------------------|---------|------------|---|------------------|-----------|
| AND PLAN  | OF CORRECTION   | IDENTIFICATION NUMBER:       | A. BUII | LDING      |   | COMPLETE         | ED        |
|           |   | 155218                       | B. WIN  |            |   | 03/03/2011       | 1         |
|           |   |                              |         |            | ADDRESS, CITY, STATE, ZIP CODE                                      |                  |           |
| NAME OF F | PROVIDER OR SUPPLIEF  | £                            |         | 2300 G     | REAT LAKES DRIVE  |                  |           |
|           | CY PLACE OF DYE   | R                            |         |            | IN46311   |                  |           |
| (X4) ID   |   | STATEMENT OF DEFICIENCIES    |         | ID         | PROVIDER'S PLAN OF CORRECTION                                       |                  | (X5)      |
| PREFIX    |   | ICY MUST BE PERCEDED BY FULL |         | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE C             | OMPLETION |
| TAG       |   | LSC IDENTIFYING INFORMATION) | +       | TAG        | DEFICIENCY)   |                  | DATE      |
|           | 1   | place feeding on hold and    |         |            | scheduled days of work, for 30 days. To ensure the deficient        |                  |           |
|           | 1   | ysician who inserted the     |         |            | practice does not recur, the  |                  |           |
|           | g-tube. The first available appointment   |                              |         |            | monitoring system established                                       | d is:            |           |
|           | with the physician was 2/21/11. The   |                              |         |            | A Performance Improvement   |                  |           |
|           | Nurse Practition  | er was notified and an       |         |            | indicator has been established                                      |                  |           |
|           | order was receiv  | ed to send the resident to   |         |            | which evaluates compliance w  |                  |           |
|           | the emergency ro  | oom to have a new g-tube     |         |            | proper technique for checking placement and water flushes           |                  |           |
|           | reinserted. At 10   | 0:00 a.m. the resident's     |         |            | according to physician order.                                       | The              |           |
|           | daughter was ma   | ade aware of the resident    |         |            | SDC, or her designee, will  |                  |           |
|           | being transferred to the emergency room for an occluded g-tube and she was also |                              |         |            | complete these indicators wee                                       | · 1              |           |
|           |   |                              |         |            | for at least 2 residents for the                                    |                  |           |
|           | ·   | g-tube was starting to rip.  |         |            | quarter and monthly thereafte with results forwarded to the         | r                |           |
|           | made aware the  | g tabe was starting to rip.  |         |            | facility performance improvem                                       | nent             |           |
|           | Pavian of a hos   | pital history and physical   |         |            | committee for further evaluation                                    |                  |           |
|           |   | mission of 2/18/11,          |         |            | or resolution until 100%  |                  |           |
|           |   |                              |         |            | compliance is achieved. POC   |                  |           |
|           | indicated a chief   | •                            |         |            | date: 3/21/2011   |                  |           |
|           | malfunctioning g  | -                            |         |            |   |                  |           |
|           |   | nt illness: The resident     |         |            |   |                  |           |
|           | had a g-tube in p   |                              |         |            |   |                  |           |
|           | *   | s malfunctioning and this    |         |            |   |                  |           |
|           | 1 ^   | sfer to the emergency        |         |            |   |                  |           |
|           | 1 -   | sing home. The resident      |         |            |   |                  |           |
|           | was seen promp  | tly by the physician who     |         |            |   |                  |           |
|           | took the resident   | for a endoscope              |         |            |   |                  |           |
|           | (inspection of bo   | ody organs or cavities       |         |            |   |                  |           |
|           |   | pe) and replacement of       |         |            |   |                  |           |
|           | ·   | external bumper of the       |         |            |   |                  |           |
|           | _   | ted to have migrated into    |         |            |   |                  |           |
|           |   | all. This was removed        |         |            |   |                  |           |
|           |   | ube was replaced.            |         |            |   |                  |           |
|           |   | olan: The resident was       |         |            |   |                  |           |
|           |   | malfunctioning g-tube.       |         |            |   |                  |           |
|           |   | nper of the tube was         |         |            |   |                  |           |
|           | i iic cateiliai bul   | uper of the tube was         |         |            |   |                  |           |
|           |   |                              |         |            |   |                  |           |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155218 |  |   | (X2) MULTIPLE CC  A. BUILDING  B. WING                                     | NSTRUCTION  | COMP  | (X3) DATE SURVEY COMPLETED 03/03/2011 |  |
|--|--|---|--|---|-------|---------------------------------------|--|
|  | PROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 |   |       |                                       |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | .D BE | (X5)<br>COMPLETION<br>DATE            |  |
|  | removal and replicates was seen post-price receive antibiotic cover for possible abdominal wall. feeds, timely distinuising home and Review of a comprovided by the at 8:00 a.m., indicates and the resident #G's dates are the flushed. She also of the peg-tube did appropriate did appropriate did appropriate flushed, ballocobserved both the attempting to flusted the flush the peg to the flush the tubes taff nurse to cale for update and in Practitioner instruction. | and required endoscopic facement. The resident ocedure and had been feeds. The resident will in the short-term to be infection of the life she tolerates tube charge back to the ticipated.  Administrator on 3/3/11 feated on 2/1/8/11 the RN complaint on behalf of |  |   |       |                                       |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218 |   |  | (X2) MULTIPLE CC  A. BUILDING  B. WING | NSTRUCTION  | COMP  | (X3) DATE SURVEY COMPLETED 03/03/2011 |  |
|--|---|--|--|---|-------|---------------------------------------|--|
|  | PROVIDER OR SUPPLIER  |  | 2300 G                                 | ADDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311   | •     |                                       |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | .D BE | (X5)<br>COMPLETION<br>DATE            |  |
|  | Practitioner was staff to sent the room. The night counseled regard Resolution: The substandard care notified.  Review of a report provided by the 8:00 a.m. The diagram occurrence involution.  Event summary/2/18/11 at abut 8 to a QMA's atter daughter, that the with her g-tube. tube the RN note occluded and por The night nurse and the RN took what had happen medications adm. "The night nurse and did not flush that she dissolve Efforts to clear than the patient with the room." | ing the incident. nurse was terminated for and public health was  ortable incident was administrator on 3/3/10 at ate of the incident was .m. It was an unusual ving Resident #G and type of injury: On the :00 a.m., it was brought ation by the resident's are resident had a problem. Upon assessing the great that the tube was uched out unnaturally. was still in the facility her aside and asked her ared during the ainistration this morning. said that she was busy at the g-tube. She did say did the meds in water. The tube were unsuccessful tent to the ER for g-tube. |  |   |       |                                       |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |                              | (X2) M        | IULTIPLE CO | NSTRUCTION  | COMPL   |            |
|--|--|------------------------------|---------------|-------------|---|---------|------------|
| THIBTETH   | or condition                             | 155218                       | 1             | LDING       |   | 03/03/2 |            |
|  |  | 1002.0                       | B. WIN        |             | DDRESS, CITY, STATE, ZIP CODE   | 00/00/2 |            |
| NAME OF I  | PROVIDER OR SUPPLIER                     |                              |               | 1           | REAT LAKES DRIVE  |         |            |
| REGENO   | CY PLACE OF DYE                          | R                            | DYER, IN46311 |             |   |         |            |
| (X4) ID  |  | TATEMENT OF DEFICIENCIES     |               | ID          | PROVIDER'S PLAN OF CORRECTION   |         | (X5)       |
| PREFIX   | •  | CY MUST BE PERCEDED BY FULL  |               | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE     | COMPLETION |
| TAG  |  | LSC IDENTIFYING INFORMATION) | -             | TAG         | DEFICIENCI)   |         | DATE       |
|  | _  | mornings medication          |               |             |   |         |            |
|  | -  | admitted to knowing the      |               |             |   |         |            |
|  |  | medication pass and          |               |             |   |         |            |
|  | stated she "cut corners" this morning as |                              |               |             |   |         |            |
|  | she was overwhe                          | elmed.                       |               |             |   |         |            |
|  | Review of the "N                         | Medication via Feeding       |               |             |   |         |            |
|  |  | wided by the Director of     |               |             |   |         |            |
|  |  | on 3/3/11 at 8:40 a.m.       |               |             |   |         |            |
|  | • • •                                    | cluded, but was not          |               |             |   |         |            |
|  | limited to, stop to                      | · ·                          |               |             |   |         |            |
| disconnect the administration set, if  |  |                              |               |             |   |         |            |
|  |  | ct tube feeding site for:    |               |             |   |         |            |
|  |  | ite, swelling, excoriation   |               |             |   |         |            |
|  |  | nage, or foul odor, check    |               |             |   |         |            |
|  | -  | cement (feeding tube         |               |             |   |         |            |
|  |  | esidual check, flush         |               |             |   |         |            |
|  | -  | n at least 30 ml of warm     |               |             |   |         |            |
|  | _  | ntraindicated, remove        |               |             |   |         |            |
|  | -  | syringe, attach the          |               |             |   |         |            |
|  |  | eding tube, and pour the     |               |             |   |         |            |
|  | medication into t                        |                              |               |             |   |         |            |
|  |  | , ,                          |               |             |   |         |            |
|  | Interview with th                        | ne DoN and the Interim       |               |             |   |         |            |
|  | DoN on 3/3/11 a                          | t 1:40 p.m., indicated the   |               |             |   |         |            |
|  |  | re never done what she       |               |             |   |         |            |
|  | did, there was no                        | reason for what she did.     |               |             |   |         |            |
|  | It was further inc                       | licated LPN #2 was           |               |             |   |         |            |
|  | terminated and w                         | vas being reported to the    |               |             |   |         |            |
|  | licensing board.                         | <b>.</b>                     |               |             |   |         |            |
|  |  |                              |               |             |   |         |            |
|  | _  | relates to Complaint         |               |             |   |         |            |
|  | IN00085845.                              |                              |               |             |   |         |            |
|  |  |                              |               |             |   |         |            |

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155218  A. BUILDING  B. WING |   |   | ONSTRUCTION  | (X3) DATE SURVEY COMPLETED 03/03/2011 |  |  |
|--------------------------|--|---|---|--|---------------------------------------|--|--|
| NAME OF F                | PROVIDER OR SUPPLIER   |   |   | ADDRESS, CITY, STATE, ZIP CODE   |                                       |  |  |
| REGENO                   | CY PLACE OF DYE  | 3   | 2300 GREAT LAKES DRIVE<br>DYER, IN46311 |  |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | COMPLETION                            |  |  |
|                          | 3.1-27(a)(3)   |   |   |  |                                       |  |  |

| REGENCY PLACE OF DYER  (X4) ID PREFIX TAG REGULATORY OR LOCAL DESTITION INFORMATION)  FO225 SS=D  Based on record review and interviews, the facility failed to ensure that all allegations of abuse were thoroughly investigated reported to the state agency for 2 of 5 allegations reviewed for abuse in the sample of 14. (Residents #O and #P)  Findings include:  The facility policy titled "Responding to and Investigating an Abuse Allegation" was reviewed on 3/3/11 at 10:00 a.m. The policy was provided by the Administrator and identified as current. The policy  STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311  STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311  STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311  STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311  STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311  STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311  SUMMARY STATEMENT OF DEFICIENCY  PREFIX REGULATORY OR LOS COMPLETION DATE  FO225  F — 225  It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: The concerns voiced by Residents O and P have been investigated with follow up and reporting to the state department of health completed as necessary. Neither resident O or P incurred any negative outcome. The corrective action taken for the recorrective action taken for the resident housing the state of the property of the province of the property | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |        |  | (X3) DATE SURVEY COMPLETED 03/03/2011               |            |
|---|---|--|---|--|--------|--|---|------------|
| REGENCY PLACE OF DYER    DYER, IN46311  | NAME OF I   | PROVIDER OR SUPPLIER   |   | •  | 1      |  |   |            |
| PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F0225  SS=D  Based on record review and interviews, the facility failed to ensure that all allegations of abuse were thoroughly investigated reported to the state agency for 2 of 5 allegations reviewed for abuse in the sample of 14. (Residents #O and #P)  Findings include:  Findings include:  The facility policy titled "Responding to and Investigating an Abuse Allegation" was reviewed on 3/3/11 at 10:00 a.m. The policy was provided by the Administrator and identified as current. The policy.   | REGENO  | CY PLACE OF DYE  | ₹   | DYER, IN46311                                    |        |  |   |            |
| the facility failed to ensure that all allegations of abuse were thoroughly investigated reported to the state agency for 2 of 5 allegations reviewed for abuse in the sample of 14. (Residents #O and #P)  Findings include:  The facility policy titled "Responding to and Investigating an Abuse Allegation" was reviewed on 3/3/11 at 10:00 a.m. The policy was provided by the Administrator and identified as current. The policy are investigated wire following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: The concerns voiced by Residents O and P have been investigated with follow up and reporting to the state department of health completed as necessary. Neither resident O or P incurred any negative outcome. The corrective action taken for   | PREFIX  | (EACH DEFICIEN   | CY MUST BE PERCEDED BY FULL   |  | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT  | Ē   | COMPLETION |
| indicated the following:  "Alleged Physical Abuse-Diffuse the situation, and remove the aggressor from all resident contact. If the resident could have an injury as a result of the alleged abuse, stabilize the resident's condition.  Contact the Executive Director and Director of Nursing immediately."  "For all abuse allegations, begin an internal investigation, immediately report the allegations to the Director of Operations, DDCO, Regional Vice President, Human Resources, and legal counsel (contact legal based upon the severity of the allegation or if further assistance is needed in the investigation)."  Indicated the following:  Inose residents naving the potential to be affected by the same deficient practice is: All residents of the nursing center. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff has been in-serviced relative to Abuse Prevention, including but not limited to, definitions of abuse and immediate reporting of abuse to the executive director and subsequent reporting to the state. Residents will be interviewed daily, Monday through Friday, for 30 days, to determine if any issues/concerns requiring further investigation are present. Investigations will be promptly  |   | the facility failed allegations of abi investigated report for 2 of 5 allegat in the sample of #P)  Findings include  The facility policiand Investigating was reviewed on policy was provious and identified as indicated the foll  "Alleged Physical situation, and remail resident contains have an injury as abuse, stabilize the Contact the Execution of Nursis "For all abuse all internal investigating the allegations to Operations, DDC President, Human counsel (contact severity of the allegations the allegations to the counsel (contact severity of the allegations to the allegations to the counsel (contact severity of the allegations to the allegations to the counsel (contact severity of the allegations to the al | to ensure that all use were thoroughly orted to the state agency ions reviewed for abuse 14. (Residents #O and and and and and and and The ded by the Administrator current. The policy owing:  al Abuse-Diffuse the move the aggressor from act. If the resident could a result of the alleged the resident's condition. Surive Director and ing immediately."  the against begin an action, immediately report to the Director of CO, Regional Vice in Resources, and legal legal based upon the legation or if further | F02  | 25     | It is the practice of this facility to ensure the highest quality of cis afforded our residents.  Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practic was: The concerns voiced by Residents O and P have been investigated with follow up and reporting to the state department of health completed as necessary. Neither resident O P incurred any negative outcorn The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents have the potential to affected, therefore, this plan of correction applies to all resident of the nursing center. The measures put into place and systemic change made to ensuth deficient practice does not recur is: Nursing center staff here in-serviced relative to Ab Prevention, including but not limited to, definitions of abuse and immediate reporting of abuse and immediate reporting to the state. Residents will be interviewed daily, Monday thro Friday, for 30 days, to determinification are presenting to the research of the presention of the presention of the state. Residents will be interviewed daily, Monday thro Friday, for 30 days, to determinificant investigation are presenting further investiga | are ne ce lent or me. be fints ure as use use g nt. | 03/21/2011 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION   |         |              | (X3) DATE SURVEY<br>COMPLETED   |                                       |                    |
|--|---|--|---------|--------------|---|---------------------------------------|--------------------|
| AND PLAN   | OF CORRECTION   | IDENTIFICATION NUMBER: 155218  | A. BUIL | BUILDING     |   |                                       |                    |
|  |   | 155216   | B. WINC |              |   | 03/03/2                               | 011                |
| NAME OF I  | PROVIDER OR SUPPLIER  |  |         |              | ADDRESS, CITY, STATE, ZIP CODE  |                                       |                    |
| REGENIC  | CY PLACE OF DYER  | 2  |         | DYER, I      | REAT LAKES DRIVE  |                                       |                    |
|  | _   |  |         |              | 11440311  |                                       | -                  |
| (X4) ID<br>PREFIX  |   | TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  | ,       | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE  |                                       | (X5)<br>COMPLETION |
| TAG  | `   | LSC IDENTIFYING INFORMATION)   | '       | TAG          | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | E                                     | DATE               |
| TAG  | 1. A Grievance Communication/ 2/15/11 was revia a.m. The Form i filed a grievance Department. Res "Therapist #2 (n rude to her and si not want her to h  The Department signed by a Certi Therapy Aide (C "Therapist has be (Therapist #2 nar with her."  The entire Comm Form was signed being complete of investigation.  Interview with the on 3/3/11 at 11:4 couple of days be grievance form the her and indicated not motivated an her. The Physica indicated that a c (did not remember) | Response Form dated ewed on 3/3/11 at 10:30 ndicated Resident #O had against the Therapy sident #O indicated ame) was very mean and he told (name) she does elp her anymore."  Response on 2/18/11 fied Occupational OTA #1) indicated |         | TAG          | initiated with appropriate reporting. To ensure the deficie practice does not recur, the monitoring system established A Performance Improvement indicator has been established which evaluates compliance winvestigating and reporting of a allegations of abuse. The DNS her representative will complet these indicators monthly for the first quarter and quarterly thereafter with results forwards to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/201 | is:<br>lith<br>any<br>s or<br>te<br>e | DATE               |

|   | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |         | LETED              |
|---|---|--|----------------|---|--|---------|--------------------|
|   |   | 155218   | A. BU<br>B. WI |   |  | 03/03/2 | 2011               |
| NAME OF I                                 | DROWINED OR CLIDDLIED                         |  | D. 111         |   | DDRESS, CITY, STATE, ZIP CODE                                      |         |                    |
|   | PROVIDER OR SUPPLIER                          |  |                | 1                                       | REAT LAKES DRIVE   |         |                    |
| REGENO                                    | CY PLACE OF DYE                               | ₹  |                | DYER, I                                 | IN46311  |         |                    |
| (X4) ID                                   |   | TATEMENT OF DEFICIENCIES                                 |                | ID                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |         | (X5)               |
| PREFIX<br>TAG                             | `   | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |                | PREFIX<br>TAG                           | CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                    | ATE     | COMPLETION<br>DATE |
|   |   | get along with the                                       |                |   |  |         |                    |
|   |   | wanted a new therapist.                                  |                |   |  |         |                    |
|   | •   | he Physical Therapist had                                |                |   |  |         |                    |
|   | •   | sts and gave Resident #O                                 |                |   |  |         |                    |
|   | -   | ner interview with the                                   |                |   |  |         |                    |
|   | Physical Therapi                              | st #1 at that time,                                      |                |   |  |         |                    |
|   | -   | not report the incident to                               |                |   |  |         |                    |
|   |   | r, nor did she document                                  |                |   |  |         |                    |
|   |   | ions with the therapist or                               |                |   |  |         |                    |
|   |   | sical Therapist #1 also                                  |                |   |  |         |                    |
|   | indicated that wh                             | nen she received the                                     |                |   |  |         |                    |
| grievance form she had done nothing else, |   |  |                |   |  |         |                    |
|   | because she had                               | already switched   |                |   |  |         |                    |
|   | therapists. She is                            | ndicated even at that                                    |                |   |  |         |                    |
|   | time, she still had                           | d not communicated with                                  |                |   |  |         |                    |
|   | the Administrato                              | r and informed her of the                                |                |   |  |         |                    |
|   | events that happe                             | ened days earlier.                                       |                |   |  |         |                    |
|   | Interview with th                             | ne Administrator on                                      |                |   |  |         |                    |
|   | 3/3/11 at 11:40 a                             | .m., indicated she was                                   |                |   |  |         |                    |
|   | unaware of the en                             | ntire situation that                                     |                |   |  |         |                    |
|   | happened in the t                             | therapy department with                                  |                |   |  |         |                    |
|   |   | the therapist. She also                                  |                |   |  |         |                    |
|   |   | ime, that a further                                      |                |   |  |         |                    |
|   | _   | he resident's complaints                                 |                |   |  |         |                    |
|   | -   | eing "mean and rude"                                     |                |   |  |         |                    |
|   |   | n completed. She also                                    |                |   |  |         |                    |
|   |   | egation of abuse had not                                 |                |   |  |         |                    |
|   | •   | the State Department of                                  |                |   |  |         |                    |
|   | Health.                                       |  |                |   |  |         |                    |
|   | 2. A Grievance                                |  |                |   |  |         |                    |
|   |   | Response Form dated                                      |                |   |  |         |                    |
|   |   |  |                |   |  |         | L                  |

PRINTED: 03/25/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218 |  |  | (X2) MULTIPLE CC  A. BUILDING  B. WING | ONSTRUCTION   | COMP   | (X3) DATE SURVEY COMPLETED 03/03/2011 |  |
|--|--|--|--|---|--------|---------------------------------------|--|
|  | PROVIDER OR SUPPLIER   |  | STREET A<br>2300 G                     | ADDRESS, CITY, STATE, ZIP COD<br>REAT LAKES DRIVE<br>IN46311  | Е      |                                       |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE            |  |
|  | a.m. The form in filed a grievance Department. Re that she did not anymore because making her feel gradients. The Communication of the therapist. The Communication came to indicated the rest to perform therapist. The Communication came to indicated was never interview with the conversation and the conv | ewed on 3/3/11 at 10:40 Indicated Resident #P had I against the Therapy Isident #P had indicated I want to attend therapy I want to attend therapy I was a way of I goofy."  I was no further I he resident's allegations I partment making her feel I was not motivated I with her. The COTA #1 I at the time, the resident I iewed, and she just I sident to another I when she received the she she did not further |  |   |        |                                       |  |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLE CO  A. BUILDING  B. WING | ONSTRUCTION  | COM    | (X3) DATE SURVEY COMPLETED 03/03/2011 |  |
|---|--|--|--|--|--------|---------------------------------------|--|
|   | OVIDER OR SUPPLIER   | ₹  | 2300 G                                 | ADDRESS, CITY, STATE, ZIP COD<br>REAT LAKES DRIVE<br>IN46311   | Е      |                                       |  |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | ILD BE | (X5)<br>COMPLETION<br>DATE            |  |
| 1   | _  | legations because the signed to another  |  |  |        |                                       |  |
| t<br>s<br>a<br>i<br>i<br>t                    | 11:40 a.m., indicathe entire situationshe did not investigable allegation of the making her feel "indicated at the tip been more investigable allegation of abustications and indicated at the tip been more investigable allegation of abustications and indicated at the tip been more investigable allegation of abustications. | dministrator on 3/3/11 at ated she was unaware of n. She further indicated tigate the resident's therapy department goofy." She also me, there should have igation to the resident's also indicated the se had not been reported rement of Health. |  |  |        |                                       |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING   |     |                              | (X3) DATE S<br>COMPL<br>03/03/2  | ETED  |                            |
|---|--|--|-----|------------------------------|--|---|----------------------------|
| REGENO  | PROVIDER OR SUPPLIER   | २  |     | STREET A<br>2300 GI<br>DYER, | ADDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  |     | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)  | Ē   | (X5)<br>COMPLETION<br>DATE |
| F0226<br>SS=D   | facility failed to was followed as investigation and abuse for 3 of 5 a reviewed in the subset of the facility policy and investigating was reviewed on policy was proviewed and identified as indicated the following was reviewed on policy was proviewed on policy was proviewed on policy was proviewed on injury as indicated the following in the facility of the internal investigation of the execution of the executi | ample of 14. (Resident  by titled "Responding to g an Abuse Allegation" 3/3/11 at 10:00 a.m. The ded by the Administrator current. The policy owing:  al Abuse-Diffuse the move the aggressor from ct. If the resident could a result of the alleged the resident's condition. The policy owing:  al Abuse-Diffuse the move the aggressor from ct. If the resident could a result of the alleged the resident's condition. The policy owing:  al Abuse-Diffuse the move the aggressor from ct. If the resident could a result of the alleged the resident's condition. The policy owing: | F02 | 26                           | It is the practice of this facility ensure the highest quality of cis afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: The concerns for resident O and P have been investigate with follow-up completed as necessary. The corrective action taken for those residents having the potential to be affected by same deficient practice is: All residents have the potential to affected, therefore, this plan of correction applies to all resident of the nursing center. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff his been in-serviced relative to Ab Prevention, including but not limited to, definitions of abuse and immediate reporting of abuse and immediate reporting to the state. Residents will be interviewed daily, Monday through the state of the state | are ne ce tF, ed on ng the be f nts ure asse use use nugh ne g nt. nt | 03/21/2011                 |

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218  A. BUILDING   |  | NSTRUCTION | (X3) DATE S<br>COMPL<br>03/03/2 | ETED  |                           |                      |
|--|--|------------|---------------------------------|---|---------------------------|----------------------|
| PROVIDER OR SUPPLIER   |  | B. WINC    | STREET A                        | ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311 |                           |                      |
| SUMMARY S (EACH DEFICIENT REGULATORY OR  1. The record for reviewed on 3/3/ in the Nursing Pr 2/7/11 at 1:00 p.r. had hit another rehead on 2/5/11.  Review of the fact 3/3/11 at 3:00 p.r. evening of 2/5/11 Resident #Q on the because she wouthe wall. The investment of the real text and the aniformed of the real tercation until the text and the aniformed of the real tercation until the side of the real tercation unti | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  TRESIDENT #F was 11 at 9:00 a.m. An entry rogress Notes dated m., indicated the resident esident in the back of the cility investigation on m., indicated that on the |            | 2300 GI                         | REAT LAKES DRIVE  | l<br>vith<br>of<br>d<br>s | (X5) COMPLETION DATE |
|  |  |            |                                 |   |                           |                      |

|                          | NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                             |               |  | (X3) DATE SURVEY COMPLETED 03/03/2011   |                                 |
|--------------------------|--|--|--|---------------|--|---|---------------------------------|
|                          | PROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  2300 GREAT LAKES DRIVE  DYER, IN46311 |               |  |   |                                 |
| (X4) ID PREFIX TAG F0226 | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | F02  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)   | TE  | (X5) COMPLETION DATE 03/21/2011 |
| SS=D                     | Communication/2/15/11 was revie a.m. The form in filed a grievance Department. Res "Therapist #2 (narude to her and so not want her to her and so not want her to her appearable (Compartment of the Department of | Response Form dated ewed on 3/3/11 at 10:30 addicated Resident #O had against the Therapy sident #O indicated ame) was very mean and the told (name) she does elp her anymore."  Response on 2/18/11 fied Occupational OTA #1) indicated as been switched out. ame) is no longer ::  """  """  """  """  """  """  """ |  |               | It is the practice of this facility ensure the highest quality of a is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practic was: The concerns for resider O and P have been investigate with follow-up completed as necessary. The corrective action taken for those residents have the potential to be affected by same deficient practice is: All residents have the potential to affected, therefore, this plan of correction applies to all reside of the nursing center. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff in been in-serviced relative to Ab Prevention, including but not limited to, definitions of abuse and immediate reporting of abuse and immediate reporting to the state. Residents will be interviewed daily, Monday through the state. Residents will be interviewed daily, Monday through the state. Residents will be interviewed daily, Monday through the state. Residents will be promptly intitated. To ensure the deficient practice does not recur, the monitoring system established a Performance Improvement | he ce to the ce |                                 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | ONSTRUCTION         | (X3) DATE SURVEY COMPLETED 03/03/2011  |  |
|--|--|---|---------------------|--|--|
|  | PROVIDER OR SUPPLIER   |   | 2300 G              | ADDRESS, CITY, STATE, ZIP CODE<br>GREAT LAKES DRIVE<br>IN46311   | 1  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE   |
|  | So at that time, the had switched the #O a new one. For Physical Therapic indicated she did the Administrator any of conversate the resident. The indicated that whe grievance form subsection because she had therapists. She is time, she still had the Administrator events that happened in the Administrator events that happened in the Resident #O and indicated at the transition of the therapist but should have been indicated the allegement to Health.  3. A Grievance Communication/ | wanted a new therapist. The Physical Therapist #1 rapists and gave Resident Further interview with the st #1 at that time, I not report the incident to r., nor did she document ions with the therapist or e Physical Therapist also hen she received the he had done nothing else, already switched indicated even at that did not communicated with r and informed her of the ened days earlier.  The Administrator on the ened days earlier.  The Administrator on the therapist. She also ime, that a further the therapist. She also ime, that a further the resident's complaints eing "mean and rude" in completed. She also egation of abuse had not the State Department of the Response Form dated ewed on 3/3/11 at 10:40 |                     | indicator has been established which evaluates compliance or reporting of and investigation any allegations of abuse. The DNS or her representative will complete these indicators monthly for the first quarter at quarterly thereafter with result forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/2011 | with of state of stat |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |   |            | (X3) DATE S   |               |                 |
|--|---|---|---|------------|---|---------------|-----------------|
|  |   | 155218  | B. WIN                                  |            |   | 03/03/20      | 011             |
| NAME OF F  | PROVIDER OR SUPPLIER  |   | <u> </u>                                |            | ADDRESS, CITY, STATE, ZIP CODE  |               |                 |
| REGENO   | CY PLACE OF DYER  | २   | 2300 GREAT LAKES DRIVE<br>DYER, IN46311 |            |   |               |                 |
| (X4) ID  |   | TATEMENT OF DEFICIENCIES  |   | ID         | PROVIDER'S PLAN OF CORRECTION   |               | (X5)            |
|  |   |   |   |            | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | E APPROPRIATE |                 |
| PREFIX<br>TAG  | REGULATORY OR  a.m. The form in filed a grievance Department. Rest that she did not wanymore because making her feel grands and the COTA #1 on attempt to have putherapist."  The Communicate signed by the Adbeing completed investigation to the of the therapy degree "goofy."  Interview with the 11:40 a.m., indicated the resit to perform therapy not want to work further indicated was never intervirus assigned the resistance. | cy MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Indicated Resident #P had against the Therapy sident #P had indicated want to attend therapy e "they have a way of goofy."  Expartment Response by 2/22/11 indicated "will patient seen by another  tion/Response Form was ministrator on 3/2/11 as There was no further the resident's allegations partment making her feel  The COTA #1 on 3/3/11 at atted the therapist in ther one day, and dent was not motivated by and the resident did with her. The COTA #1 at the time, the resident tewed, and she just |   | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA                | TE            | COMPLETION DATE |
|  | did not inform th   | e Administrator of the  |   |            |   |               |                 |
|  |   | when she received the   |   |            |   |               |                 |
|  |   | legations because the   |   |            |   |               |                 |

Facility ID:

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |         |          | (X3) DATE SURVEY COMPLETED 03/03/2011                        |     |                      |
|--|--|--|---------|----------|--|-----|----------------------|
|  | PROVIDER OR SUPPLIER   |  | p. wiiv | STREET A | DDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311 |     |                      |
|  | SUMMARY S (EACH DEFICIEN REGULATORY OR resident was reas therapist.  Interview with A 11:40 a.m., indic the entire situatio she did not inves allegation of the making her feel ' indicated at the ti been more invest complaints. She allegation of abu |  |         | STREET A | REAT LAKES DRIVE   | ATE | (X5) COMPLETION DATE |
|  |  |  |         |          |  |     |                      |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | (X2) MULTIPLE CONSTRUCTION   |               |        | (X3) DATE SURVEY   |          |            |
|--|---------------------|------------------------------|---------------|--------|--|----------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER:       | A. BUII       | DING   |  | COMPL    | ETED       |
|  |                     | 155218                       | B. WIN        |        |  | 03/03/2  | 011        |
|  |                     |                              | D. (/11)      |        | ADDRESS, CITY, STATE, ZIP CODE   | <u> </u> |            |
| NAME OF F  | ROVIDER OR SUPPLIER |                              |               | l      | REAT LAKES DRIVE   |          |            |
|  | Y PLACE OF DYE      | ₹                            | DYER, IN46311 |        |  |          |            |
| (X4) ID  |                     | TATEMENT OF DEFICIENCIES     |               | ID     | PROVIDER'S PLAN OF CORRECTION  |          | (X5)       |
| PREFIX   | •                   | CY MUST BE PERCEDED BY FULL  |               | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | ſΈ       | COMPLETION |
| TAG  |                     | LSC IDENTIFYING INFORMATION) |               | TAG    | ·  |          | DATE       |
| F0250  |                     | review and interview, the    | F02           | 50     | F <b>–</b> 250   |          | 03/21/2011 |
| SS=D   | <u>-</u>            | ensure medically-related     |               |        | It is the practice of this facility  | to       |            |
|  | social services w   | ere provided to 1 of 1       |               |        | ensure the highest quality of c  |          |            |
|  | residents who ex    | hibited an increase in       |               |        | is afforded our residents.   |          |            |
|  | behaviors in the    | sample of 14 related to      |               |        | Consistent with this practice, the   | he       |            |
|  | arranging counse    | eling services and           |               |        | following has been done: The   |          |            |
|  |                     | viors. (Resident #F)         |               |        | corrective action taken for the  |          |            |
|  | 8 11 8 11           | ,                            |               |        | residents found to have been<br>affected by the deficient praction                     | 00       |            |
|  | Findings include    | -                            |               |        | was: Resident F has received   | 26       |            |
|  | i manigs merade     | •                            |               |        | Senior Counseling Services. T  | he       |            |
|  | The record for D    | esident #F was reviewed      |               |        | corrective action taken for thos   |          |            |
|  |                     |                              |               |        | residents having the potential   |          |            |
|  |                     | a.m. The resident's          |               |        | be affected by the same defici   |          |            |
|  | _                   | ed, but were not limited     |               |        | practice is: The medical record  |          |            |
|  |                     | n behavioral disturbance.    |               |        | of all residents have been aud to identify any outstanding                             | itea     |            |
|  | A Physician's Or    | der written on 1/24/11,      |               |        | referrals with follow up   |          |            |
|  | indicated the resi  | dent was to be seen by       |               |        | implemented, as necessary. T   | he       |            |
|  | Senior Counselin    | ng Services related to       |               |        | measures put into place and  |          |            |
|  | grieving loss of h  | nusband with behaviors.      |               |        | systemic change made to ensi   |          |            |
|  |                     |                              |               |        | the deficient practice does not  |          |            |
|  | An entry in the N   | Jursing Progress Notes       |               |        | recur is: Nursing center staff a social services staff has been                        | nd       |            |
|  |                     | :20 a.m., indicated orders   |               |        | in-serviced relative to appropri   | ate      |            |
|  |                     | e chart for the resident to  |               |        | interventions to implement who   |          |            |
|  |                     |                              |               |        | residents exhibit behaviors, an  |          |            |
|  | _                   | r Counseling Services for    |               |        | ensuring referrals are followed  |          |            |
|  |                     | eatment related to           |               |        | on timely. To ensure the defici  | ent      |            |
|  | , 0                 | spouse with behaviors.       |               |        | practice does not recur, the   |          |            |
|  | _                   | oing to endorse to the       |               |        | monitoring system established<br>A Performance Improvement                             | is.      |            |
|  | next shift to notif | -                            |               |        | indicator has been established   | ,        |            |
|  |                     | of the order. There was      |               |        | which evaluates compliance w   |          |            |
|  | no documentation    | n in the resident's record   |               |        | appropriate intervention and   |          |            |
|  | from Senior Cou     | nseling Services.            |               |        | referrals for residents exhibitin  |          |            |
|  |                     | -                            |               |        | behaviors. SSD, or designee,   |          |            |
|  | An entry in the N   | Jursing Progress Notes       |               |        | be responsible to review behave  | vior     |            |
|  |                     | :00 p.m., completed by       |               |        | audit tool daily, on scheduled days of work, during morning                            |          |            |
|  |                     | r, tomplette of              |               |        |  |          |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155218 |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |  |                     | (X3) DATE SURVEY COMPLETED 03/03/2011   |                    |                            |
|--|---|--|--|---------------------|---|--------------------|----------------------------|
|  | PROVIDER OR SUPPLIER  |  | B. WING G5/03/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  2300 GREAT LAKES DRIVE  DYER, IN46311 |                     |   |                    |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OR   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   |                    | (X5)<br>COMPLETION<br>DATE |
|  | resident had hit a 2/5/11 due to the wall and would r of 2/7/11, the res Resident #D in the without being properties of the facility process. A Nurse Practition indicated the resident's sister with facility psychemically and process. A Nurse Practition indicated the resident and indicated the resident was blank and physically all was blank 2/1-2/behaviors on 2/5 listed on the flow. The Quarterly Massessment (MD indicated the resident and physically all was blank 2/1-2/behaviors on 2/5 listed on the flow. | w. Haldol 1 mg by by for seven days and e and treat.  11 Behavior Monthly ated the resident had the ally abusive, wanders, busive. The flow sheet 3 and 2/5-2/10/11. The and 2/7/11 were not |  |                     | meeting. SSD, or designee, we complete the indicators month for the first quarter and quarter thereafter with results forward to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/20 | nly<br>erly<br>led |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER:  A. BUILDING  B. WING |   |  |                     | NSTRUCTION   | (X3) DATE<br>COMP<br>03/03/2 | LETED                      |
|--|---|--|---------------------|--|------------------------------|----------------------------|
|  | PROVIDER OR SUPPLIER  |  | STREET A<br>2300 G  | ADDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311  |                              |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | D BE                         | (X5)<br>COMPLETION<br>DATE |
| TAG  | The resident was Psychiatric Nurs  Interview with S Member #1 on 3 indicated when a services were ob to inform Social and then the order appropriate agen with Social Servindicated Senior were not faxed the further indicated resident's payor status not that was original the Social Service. | seen by the facility e Practitioner on 2/10/11.  ocial Service Staff /3/11 at 1:25 p.m., order for psychiatric tained, Nursing staff were Service staff of the order er was faxed to the cy. Further interview ice Staff Member #1, Counseling Services ne order until 2/3/11. She that she had to re-fax the status on 3/1/11 due to the listed on the face sheet ly faxed. As of 3/3/11, se staff member indicated not been seen by Senior | TAG                 | DEFICIENCY   |                              | DATE                       |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                     |                              | (X2) MULTIPLE CONSTRUCTION              |        |   | COMPL         |            |
|---|---------------------|------------------------------|---|--------|---|---------------|------------|
| ANDILAN                                       | or correction       | 155218                       | A. BUII                                 |        |   | 03/03/20      |            |
|   |                     | 100210                       | B. WIN                                  |        |   | 03/03/20      | J 1 1      |
| NAME OF P                                     | ROVIDER OR SUPPLIER |                              |   |        | ADDRESS, CITY, STATE, ZIP CODE                                      |               |            |
| REGENC  | Y PLACE OF DYER     | २                            | 2300 GREAT LAKES DRIVE<br>DYER, IN46311 |        |   |               |            |
| (X4) ID                                       | SUMMARY S           | TATEMENT OF DEFICIENCIES     |   | ID     | PROVIDER'S PLAN OF CORRECTION                                       |               | (X5)       |
| PREFIX  | (EACH DEFICIEN      | CY MUST BE PERCEDED BY FULL  |   | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TΕ            | COMPLETION |
| TAG   | REGULATORY OR       | LSC IDENTIFYING INFORMATION) |   | TAG    | DEFICIENCY)   |               | DATE       |
| F0282   | Based on observa    | ation, record review and     | F02                                     | 82     | F - 282   |               | 03/21/2011 |
| SS=G  | interview, the fac  | cility failed to ensure      |   |        | It is the practice of this facility                                 | <sub>to</sub> |            |
|   | physician's order   | s were followed as           |   |        | ensure the highest quality of c                                     |               |            |
|   | written related to  | obtaining a consultation     |   |        | is afforded our residents.  |               |            |
|   | for psychiatric co  | ounseling services and       |   |        | Consistent with this practice, t                                    | he            |            |
|   | having leg rests of | on the wheelchair as         |   |        | following has been done: The  |               |            |
|   |                     | 14 sampled residents.        |   |        | corrective action taken for the residents found to have been        |               |            |
|   |                     | d #O) The facility also      |   |        | affected by the deficient practi                                    | ce            |            |
|   | `                   | he plan of care was          |   |        | was: Resident F has received  |               |            |
|   |                     | en related to foley          |   |        | Senior Counseling Services.   |               |            |
|   |                     | 1 of 2 residents who had     |   |        | Resident G's urinary drainage                                       |               |            |
|   |                     | n the sample of 14 and       |   |        | bag was placed in a dignity ba<br>off the floor and her PEG tube    | · .           |            |
|   | -                   | he resident's peg tube (     |   |        | was flushed during the survey                                       |               |            |
|   |                     | doscopic gastrostomy         |   |        | Resident O had leg rests appl                                       |               |            |
|   |                     | for nutritional purposes)    |   |        | to wheelchair. The corrective                                       |               |            |
|   |                     | r to the resident receiving  |   |        | action taken for those residen                                      |               |            |
|   | medications thro    | •                            |   |        | having the potential to be affective by the same deficient practice |               |            |
|   |                     |                              |   |        | The medical records of all  | 15.           |            |
|   |                     | eg tube become clogged       |   |        | residents have been audited to                                      | o             |            |
|   | _                   | going to the hospital to     |   |        | identify any outstanding referr                                     |               |            |
|   | nave the peg tube   | e replaced. (Resident #G)    |   |        | with follow up implemented, as                                      |               |            |
|   | Tr. 1               |                              |   |        | necessary. Residents with fol catheters have been visually          | ey            |            |
|   | Findings include    | :                            |   |        | observed to ensure presence   | of            |            |
|   |                     |                              |   |        | dignity bags. An audit has be                                       |               |            |
|   |                     | r Resident #F was            |   |        | conducted to ensure necessar  | у             |            |
|   |                     | 11 at 9:00 a.m. The          |   |        | assistive devices are in use. A                                     |               |            |
|   | _                   | ses included, but were       |   |        | residents of the nursing center                                     |               |            |
|   |                     | ementia with behavioral      |   |        | with enteral feeding tubes have the potential to be affected,       | c             |            |
|   | disturbance. A P    | hysician's Order written     |   |        | therefore, this plan of correction                                  | on            |            |
|   | on 1/24/11, indic   | ated the resident was to     |   |        | applies to all residents with                                       |               |            |
|   | be seen by Senio    | r Counseling Services        |   |        | enteral feeding tubes.The   |               |            |
|   | related to grievin  | g loss of husband with       |   |        | measures put into place and systemic change made to ens             | ure           |            |
|   | behaviors.          |                              |   |        | the deficient practice does not                                     |               |            |
|   |                     |                              |   |        | recur is: Nursing center staff h                                    |               |            |
|   |                     |                              |   |        |   |               |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON |                      |                              | ONSTRUCTION | (X3) DATE S | SURVEY   |              |            |
|--|----------------------|------------------------------|-------------|-------------|--|--------------|------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BUII     | DING        | COMPLETED  |              | ETED       |
|  |                      | 155218                       | 1           |             |  | 03/03/20     | 011        |
|  |                      |                              | B. WIN      |             | ADDRESS, CITY, STATE, ZIP CODE   |              |            |
| NAME OF F  | PROVIDER OR SUPPLIER | 8                            |             |             |  |              |            |
| DECENIC  |                      | n                            |             |             | REAT LAKES DRIVE   |              |            |
| REGENC   | CY PLACE OF DYE      | K                            |             | DIEK,       | IN46311  |              |            |
| (X4) ID  | SUMMARY S            | TATEMENT OF DEFICIENCIES     |             | ID          | PROVIDER'S PLAN OF CORRECTION  |              | (X5)       |
| PREFIX   | (EACH DEFICIEN       | CY MUST BE PERCEDED BY FULL  |             | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE | re           | COMPLETION |
| TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION) |             | TAG         | DEFICIENCY)  |              | DATE       |
|  | An entry in the N    | Nursing Progress Notes       |             |             | been in-serviced relative to   |              |            |
|  | dated 2/3/11 at 1    | :20 a.m., indicated orders   |             |             | appropriate interventions to   |              |            |
|  |                      | e chart for the resident to  |             |             | implement when residents exh   |              |            |
|  |                      | or Counseling Services for   |             |             | behaviors, and ensuring referr   | als          |            |
|  | · -                  | _                            |             |             | are followed up on timely. Licensed nurses and C.N.A.'s                  |              |            |
|  |                      | reatment related to          |             |             | have been in-serviced relative   |              |            |
|  | -                    | spouse with behaviors.       |             |             | foley catheters, including but r   |              |            |
|  | The nurse was go     | oing to endorse to the       |             |             | limited to ensuring a dignity ba   |              |            |
|  | next shift to noti   | fy the family at a           |             |             | in use. Nursing center staff ha  |              |            |
|  |                      | of the order. There was      |             |             | been in-serviced relative to the   |              |            |
|  |                      | n in the resident's record   |             |             | importance of ensuring assisti   | ve           |            |
|  |                      | nseling Services.            |             |             | devices are in use in accordar   | ıce          |            |
|  | Hom Semor Cou        | insering services.           |             |             | with physician orders and  |              |            |
|  |                      |                              |             |             | careplans. Licensed nursing s  |              |            |
|  | Interview with S     | ocial Service Staff          |             |             | has been in-serviced related to  | )            |            |
|  | Member #1 on 3       | /3/11 at 1:25 p.m.,          |             |             | care of enteral feeding tubes,   |              |            |
|  | indicated when a     | in order for psychiatric     |             |             | including but not limited to pro<br>technique for checking placem        |              |            |
|  |                      | tained, Nursing staff were   |             |             | and water flushes according to   |              |            |
|  |                      | Service staff of the order   |             |             | physician order. Licensed nur  |              |            |
|  |                      |                              |             |             | will complete a competency   |              |            |
|  |                      | er was faxed to the          |             |             | check off with return  |              |            |
|  |                      | cy. Further interview        |             |             | demonstration to ensure prope  | er           |            |
|  | with Social Serv     | ice Staff Member #1,         |             |             | technique. To ensure the   |              |            |
|  | indicated Senior     | Counseling Services          |             |             | deficient practice does not rec  | ur,          |            |
|  | were not faxed th    | ne order until 2/3/11. She   |             |             | the monitoring system  |              |            |
|  | further indicated    | that she had to re-fax the   |             |             | established is: A Performance  | ,            |            |
|  |                      | status on 3/1/11 due to the  |             |             | Improvement indicator that   |              |            |
|  |                      |                              |             |             | monitors foley catheters, peg  |              |            |
|  | ^ -                  | listed on the face sheet     |             |             | tubes and assistive devices have been established which evaluation       |              |            |
|  |                      | ly faxed. As of $3/3/11$ ,   |             |             | compliance with ensuring   | 1100         |            |
|  | the Social Service   | e staff member indicated     |             |             | physician orders and careplan  | <sub>s</sub> |            |
|  | the resident had     | not been seen by Senior      |             |             | are followed. The DNS or her   | -            |            |
|  | Counseling Serv      | ices.                        |             |             | representative will complete th  | iese         |            |
|  |                      |                              |             |             | indicators monthly for the first   |              |            |
|  |                      |                              |             |             | quarter and quarterly thereafte  |              |            |
|  |                      |                              |             |             | with results forwarded to the  |              |            |
|  |                      |                              |             |             | facility performance improvem  |              |            |
|  |                      |                              |             |             | committee for further evaluation   | n            |            |
|  |                      |                              |             |             |  |              |            |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                     |  | A. BUILDING   | UNSTRUCTION   | COMPLETED  03/03/2011              |  |  |  |
|---|---------------------|--|---|---|------------------------------------|--|--|--|
|   |                     | 155218   | B. WING   |   | 03/03/2011                         |  |  |  |
| NAME OF F                                     | ROVIDER OR SUPPLIER |  | STREET ADDRESS, CITY, STATE, ZIP CODE  2300 GREAT LAKES DRIVE |   |                                    |  |  |  |
| REGENO  | CY PLACE OF DYE     | ₹  |   | IN46311   | _                                  |  |  |  |
| (X4) ID                                       |                     | TATEMENT OF DEFICIENCIES                                 | ID  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE  | (X5)                               |  |  |  |
| PREFIX<br>TAG                                 | •                   | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG   | CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | COMPLETION DATE                    |  |  |  |
| IAU   | REGULATORI OR       | LOC IDENTIFY TING INFORMATION)                           | IAU   | or resolution until 100% compliance is achieved. A Performance Improvement indicator has been established which evaluates compliance proper technique for checking placement and water flushes according to physician order. Staff Development Coordinator designee, shall observe endeding tube procedures for a least 2 residents daily, on scheduled days of work, for a days and monthly there after. The results will be forwarded the performance improvement committee for further evaluator resolution until 100% compliance is achieved. POC date: 3/21/2011 | ed with g The tor, nteral at to nt |  |  |  |

| STATEMENT OF DEFICIENCIES (X1) PR |                     | X1) PROVIDER/SUPPLIER/CLIA   |                     |        | (X3) DATE S  | (3) DATE SURVEY |            |
|-----------------------------------|---------------------|------------------------------|---------------------|--------|--|-----------------|------------|
| AND PLAN                          | OF CORRECTION       | IDENTIFICATION NUMBER:       | A. BUILDING         |        |  | COMPL           | ETED       |
|                                   |                     | 155218                       | A. BUILDING B. WING |        |  | 03/03/2011      |            |
|                                   |                     |                              | D. WIIV             |        | ADDRESS, CITY, STATE, ZIP CODE                                       |                 |            |
| NAME OF F                         | ROVIDER OR SUPPLIER |                              |                     | l      | REAT LAKES DRIVE   |                 |            |
| REGENO                            | Y PLACE OF DYE      | र                            |                     | l      | IN46311  |                 |            |
| (X4) ID                           | SUMMARY S           | TATEMENT OF DEFICIENCIES     |                     | ID     | PROVIDER'S PLAN OF CORRECTION  |                 | (X5)       |
| PREFIX                            | (EACH DEFICIEN      | CY MUST BE PERCEDED BY FULL  |                     | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ſΕ              | COMPLETION |
| TAG                               | REGULATORY OR       | LSC IDENTIFYING INFORMATION) | ļ                   | TAG    | DEFICIENCY)  |                 | DATE       |
| F0282                             | 2. On 3/2/11 at 1   | 2:45 p.m. and at 2:15        | F02                 | 82     | F - 282  |                 | 03/21/2011 |
| SS=G                              | p.m., Resident #0   | O was observed sitting in    |                     |        | _  |                 |            |
| 00-0                              | _                   | with both of her feet on     |                     |        | It is the practice of this facility                                  |                 |            |
|                                   |                     | were no leg rests noted      |                     |        | ensure the highest quality of c                                      | are             |            |
|                                   |                     | _                            |                     |        | is afforded our residents.  Consistent with this practice, to        | he              |            |
|                                   |                     | r and her legs were          |                     |        | following has been done: The   | .ic             |            |
|                                   | observed in the d   | lependent position.          |                     |        | corrective action taken for the                                      |                 |            |
|                                   |                     |                              |                     |        | residents found to have been   |                 |            |
|                                   | On 3/3/11 at 9:30   | a.m., Resident #O was        |                     |        | affected by the deficient practi-                                    | ce              |            |
|                                   | observed in bed.    | At that time, the South      |                     |        | was: Resident F has received   |                 |            |
|                                   | Unit Manager rei    | moved the resident's         |                     |        | Senior Counseling Services.  |                 |            |
|                                   | _                   | ockings (ted) hose and       |                     |        | Resident G's urinary drainage  |                 |            |
|                                   | _                   | assessment. The              |                     |        | bag was placed in a dignity ba                                       |                 |            |
|                                   | _                   |                              |                     |        | off the floor and her PEG tube                                       |                 |            |
|                                   | _                   | ere edematous and            |                     |        | was flushed during the survey Resident O had leg rests appli         |                 |            |
|                                   | slightly red in co  |                              |                     |        | to wheelchair. The corrective  | Eu              |            |
|                                   | resident's feet we  | ere edematous. The           |                     |        | action taken for those resident                                      | s               |            |
|                                   | resident was obse   | erved with deep tissue       |                     |        | having the potential to be affect                                    |                 |            |
|                                   | injury to her left  | heel. The area was dark      |                     |        | by the same deficient practice                                       |                 |            |
|                                   | red with no drain   |                              |                     |        | The medical records of all   |                 |            |
|                                   | rea with no aram    | inge.                        |                     |        | residents have been audited to                                       | )               |            |
|                                   | T4                  |                              |                     |        | identify any outstanding referra                                     |                 |            |
|                                   |                     | ne resident at that time,    |                     |        | with follow up implemented, as                                       |                 |            |
|                                   | _                   | s hurt because of the        |                     |        | necessary. Residents with fold                                       | <b>ә</b> у      |            |
|                                   | swelling.           |                              |                     |        | catheters have been visually observed to ensure presence             | of              |            |
|                                   |                     |                              |                     |        | dignity bags. An audit has been                                      |                 |            |
|                                   | On 3/3/11 at 10:0   | 00 a.m., Resident# O was     |                     |        | conducted to ensure necessar   |                 |            |
|                                   |                     | in her wheelchair in the     |                     |        | assistive devices are in use. A                                      | -               |            |
|                                   | _                   | n in a church activity.      |                     |        | residents of the nursing center                                      |                 |            |
|                                   | _                   | ent's legs were in the       |                     |        | with enteral feeding tubes hav                                       | e               |            |
|                                   |                     | •                            |                     |        | the potential to be affected,  |                 |            |
|                                   |                     | on and there were no         |                     |        | therefore, this plan of correction                                   | n l             |            |
|                                   | _                   | ests observed on the her     |                     |        | applies to all residents with  |                 |            |
|                                   | chair.              |                              |                     |        | enteral feeding tubes.The  |                 |            |
|                                   |                     |                              |                     |        | measures put into place and  | ure             |            |
|                                   | The record for R    | esident #O was reviewed      |                     |        | systemic change made to ensi<br>the deficient practice does not      |                 |            |
|                                   | on 3/2/11 at 12:4   | 5 p.m. Review of             |                     |        | recur is: Nursing center staff h                                     |                 |            |
|                                   |                     | 1                            |                     |        |  |                 |            |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |   | A. BUILDING   | E CONSTRUCTION      | COMPLI<br>03/03/20  | ETED   |                      |
|---|---|---|---------------------|---|--|----------------------|
|   |   | 1   | B. WING             | EET ADDRESS, CITY, STATE, ZIP CODE  | 1  |                      |
| NAME OF I   | PROVIDER OR SUPPLIE   | 3   |                     | O GREAT LAKES DRIVE   |  |                      |
|   | CY PLACE OF DYE   |   | DYE                 | ER, IN46311   |  |                      |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN<br>REGULATORY OR   | ETATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)  Light dated 2/11/11 indicated   | ID<br>PREFIZ<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  been in-serviced relative to  | ATE  | (X5) COMPLETION DATE |
|   | "Encourage resident two foot rests the Interview with the 3/3/11 at 9:45 a. | dated 2/11/11 indicated dent to elevate legs, needs at will elevate her legs."  The South Unit Manager on m., indicated the resident rests on her wheelchair. |                     | been in-serviced relative to appropriate interventions to implement when residents expensively. Licensed nurses and C.N.A.' have been in-serviced relative foley catheters, including but limited to ensuring a dignity bein use. Nursing center staff in been in-serviced relative to the importance of ensuring assisted devices are in use in accordate with physician orders and careplans. Licensed nursing has been in-serviced related care of enteral feeding tubes including but not limited to provide technique for checking place and water flushes according physician order. Licensed nursing technique. To ensure the deficient practice does not restrain the deficient practice does not restrain the monitoring system established is: A Performance Improvement indicator that monitors foley catheters, pegubles and assistive devices in been established which evaluate compliance with ensuring physician orders and carepla are followed. The DNS or he representative will complete indicators monthly for the first quarter and quarterly thereaf with results forwarded to the facility performance improver committee for further evaluate. | s e to not pag is nas ne tive ance staff to poper ment to pas pas per cur, ce nas pates in these to ter ment |                      |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |                     | A. BUILDING  | UNSTRUCTION   | COMPLETED  03/03/2011   |                                    |
|---|---------------------|--|---------------|---|------------------------------------|
|   |                     | 100210   | B. WING       |   | 03/03/2011                         |
| NAME OF F   | ROVIDER OR SUPPLIER |  | l l           | ADDRESS, CITY, STATE, ZIP CODE<br>SREAT LAKES DRIVE   |                                    |
| REGENO  | CY PLACE OF DYE     | ₹  | DYER,         | _   |                                    |
| (X4) ID   |                     | TATEMENT OF DEFICIENCIES                                 | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE  | (X5)                               |
| PREFIX<br>TAG   | •                   | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | COMPLETION DATE                    |
| IAU   | REGULATORI OR       | LOC IDENTIFY TING INFORMATION)                           | IAU           | or resolution until 100% compliance is achieved. A Performance Improvement indicator has been established which evaluates compliance proper technique for checking placement and water flushes according to physician order. Staff Development Coordinator designee, shall observe endeding tube procedures for a least 2 residents daily, on scheduled days of work, for a days and monthly there after. The results will be forwarded the performance improvement committee for further evaluator resolution until 100% compliance is achieved. POC date: 3/21/2011 | ed with g The tor, nteral at to nt |

| A. BUILDING  |                            |
|--|----------------------------|
| 155218 — — — — — — — — — — — — — — — — — — —   | 1                          |
| NAME OF PROVIDER OR SUPPLIER  REGENCY PLACE OF DYER  STREET ADDRESS, CITY, STATE, ZIP CODE  2300 GREAT LAKES DRIVE  DYER, IN46311  |                            |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CONTROL OF THE APPROPRIATE DEFICIENCY  | (X5)<br>COMPLETION<br>DATE |
| F0282 SS=G  3. On 3/3/11 at 7:10 a.m. Resident #G was observed in bed with her foley bag laying on the mat on the floor by her bed. The foley bag was not contained in a dignity bag (a bag used to hold the foley catheter bag so that it cannot be seen or touch the floor).  On 3/3/11 at 7:20 a.m. Resident #G was observed in bed with her foley bag laying on the floor mat beside her bed. The CNA moved the floor mat and the bottom of the foley bag was not contained in a dignity bag.  On 3/3/11 at 8:55 a.m. the resident was observed in bed with her foley bag touching the floor mat beside her bed and the floor. The foley bag was not contained in a dignity bag.  On 3/3/11 at 9:45 a.m. the resident was observed in bed with her foley bag touching the mat on the floor beside her bed and the floor. The foley bag was not contained in a dignity bag.  The resident's record was reviewed on 3/3/11 at 7:35 a.m. The record for Resident #G was reviewed on 3/3/11 at 7:35 a.m. The resident's diagnoses included, but was not limited to, cerebral | 03/21/2011                 |

| l '               |                                       |  | (X2) MULTIPLE CONSTRUCTION (X |                                |  | X3) DATE SURVEY |                    |
|-------------------|---------------------------------------|--|-------------------------------|--------------------------------|--|-----------------|--------------------|
| AND PLAN          | OF CORRECTION                         | IDENTIFICATION NUMBER:                                 | A. BUI                        | DING                           |  | COMPL           | ETED               |
|                   |                                       | 155218   | B. WIN                        |                                |  | 03/03/2         | 011                |
|                   | STREET ADDRESS, CITY, STATE, ZIP CODE |  |                               | ADDRESS, CITY, STATE, ZIP CODE |  |                 |                    |
| NAME OF           | PROVIDER OR SUPPLIEF                  | 2  |                               | 1                              | REAT LAKES DRIVE   |                 |                    |
| REGENO            | CY PLACE OF DYE                       | R  |                               | 1                              | IN46311  |                 |                    |
|                   |                                       |  |                               | <u> </u>                       |  |                 | (375)              |
| (X4) ID<br>PREFIX |                                       | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL |                               | ID<br>PREFIX                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE   |                 | (X5)<br>COMPLETION |
| TAG               | ·                                     | LSC IDENTIFYING INFORMATION)                           |                               | TAG                            | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)                       | ΤE              | DATE               |
| IAG               |                                       | ·  | +                             | IAG                            | been in-serviced relative to   |                 | DAIL               |
|                   |                                       | t (CVA, Stroke), chronic                               |                               |                                | appropriate interventions to   |                 |                    |
|                   |                                       | et infection), and                                     |                               |                                | implement when residents exh   | nibit           |                    |
|                   | dysphasia (impa                       | irment of speech).                                     |                               |                                | behaviors, and ensuring referr                                       |                 |                    |
|                   |                                       |  |                               |                                | are followed up on timely.   |                 |                    |
|                   | A care plan initia                    | ated on 6/25/10, indicated                             |                               |                                | Licensed nurses and C.N.A.'s   |                 |                    |
|                   | a problem of at r                     | isk for complications                                  |                               |                                | have been in-serviced relative                                       |                 |                    |
|                   | related to foley of                   | eatheter usage. The                                    |                               |                                | foley catheters, including but r<br>limited to ensuring a dignity ba |                 |                    |
|                   | 1                                     | ided but were not limited                              |                               |                                | in use. Nursing center staff ha                                      |                 |                    |
|                   |                                       | bag in a dignity bag for                               |                               |                                | been in-serviced relative to the                                     |                 |                    |
|                   | privacy.                              | oug in a dignity oug for                               |                               |                                | importance of ensuring assisti                                       |                 |                    |
|                   | privacy.                              |  |                               |                                | devices are in use in accordar                                       | ice             |                    |
|                   | 0 2/2/10 11                           | 10 : 4 : : :4 4  |                               |                                | with physician orders and  |                 |                    |
|                   |                                       | 0 p.m. interview with the                              |                               |                                | careplans. Licensed nursing s  |                 |                    |
|                   |                                       | sing and Interim Director                              |                               |                                | has been in-serviced related to                                      | )               |                    |
|                   | of Nursing, it wa                     | is indicated that the foley                            |                               |                                | care of enteral feeding tubes, including but not limited to pro      | ner             |                    |
|                   | bag of Resident                       | #G was observed last                                   |                               |                                | technique for checking placem  |                 |                    |
|                   | night. The Direct                     | ctor of Nursing indicated                              |                               |                                | and water flushes according to                                       |                 |                    |
|                   | she thought to go                     | et a dignity bag but had                               |                               |                                | physician order. Licensed nur  |                 |                    |
|                   | 1                                     | dignity bag for the                                    |                               |                                | will complete a competency   |                 |                    |
|                   | resident.                             |  |                               |                                | check off with return  |                 |                    |
|                   |                                       |  |                               |                                | demonstration to ensure prope  | er              |                    |
|                   | 1 A nursing not                       | e dated 2/18/11 at 8:00                                |                               |                                | technique. To ensure the deficient practice does not rec             | ur              |                    |
|                   | 1                                     |  |                               |                                | the monitoring system  | ui,             |                    |
|                   |                                       | ne Resident #G was in                                  |                               |                                | established is: A Performance  | ,               |                    |
|                   |                                       | le to flush g-tube                                     |                               |                                | Improvement indicator that   |                 |                    |
|                   | (gastrostomy tub                      |  |                               |                                | monitors foley catheters, peg  |                 |                    |
|                   |                                       | oses). The resident's                                  |                               |                                | tubes and assistive devices ha                                       |                 |                    |
|                   | feeding had clog                      | ged the tube. Several                                  |                               |                                | been established which evalua  | ates            |                    |
|                   | attempts were m                       | ade without success to                                 |                               |                                | compliance with ensuring physician orders and careplan               | و ا             |                    |
|                   | unclog the tube.                      | Bowel sounds were                                      |                               |                                | are followed. The DNS or her   | ى<br>ا          |                    |
|                   | _                                     | bdominal quadrants.                                    |                               |                                | representative will complete th                                      | ese l           |                    |
|                   | 1 ^                                   | nderness noted. No facial                              |                               |                                | indicators monthly for the first                                     |                 |                    |
|                   |                                       | time. At 8:30 a.m. the                                 |                               |                                | quarter and quarterly thereafte                                      | er              |                    |
|                   | 1 ~                                   | er was notified. An order                              |                               |                                | with results forwarded to the  | ,               |                    |
|                   |                                       |  |                               |                                | facility performance improvem  |                 |                    |
|                   | was received to                       | place feeding on hold and                              |                               |                                | committee for further evaluation                                     | )TI             |                    |
|                   |                                       |  |                               |                                |  |                 |                    |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) M                       | ULTIPLE CO         | (X3) DATE SURVEY |  |                    |  |
|--|---|------------------------------|--------------------|------------------|--|--------------------|--|
| AND PLAN   | OF CORRECTION                             | IDENTIFICATION NUMBER:       | A. BUILDING        |                  |  | COMPLETED          |  |
|  |   | 155218                       | B. WING 03/03/2011 |                  |  |                    |  |
| NAME OF F  | PROVIDER OR SUPPLIER                      |                              | -                  | STREET A         | ADDRESS, CITY, STATE, ZIP CODE   | -                  |  |
|  |   |                              |                    |                  | REAT LAKES DRIVE   |                    |  |
| REGENO   | CY PLACE OF DYEF                          | ₹                            |                    | DYER,            | IN46311  |                    |  |
| (X4) ID  |   | TATEMENT OF DEFICIENCIES     |                    | ID               | PROVIDER'S PLAN OF CORRECTION  | (X5)               |  |
| PREFIX   | (EACH DEFICIENCY MUST BE PERCEDED BY FULL |                              |                    | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) |                    |  |
| TAG  |   | LSC IDENTIFYING INFORMATION) | -                  | TAG              | or resolution until 100%   | DATE               |  |
|  |   | ysician who inserted the     |                    |                  | compliance is achieved. A  |                    |  |
|  | _   | available appointment        |                    |                  | Performance Improvement  |                    |  |
|  |   | n was 2/21/11. The           |                    |                  | indicator has been established   | t l                |  |
|  |   | er was notified and an       |                    |                  | which evaluates compliance w   | vith               |  |
|  |   | ed to send the resident to   |                    |                  | proper technique for checking  |                    |  |
|  |   | oom to have a new g-tube     |                    |                  | placement and water flushes according to physician order.                              | - <sub>he</sub>    |  |
|  |   | 0:00 a.m. the resident's     |                    |                  | Staff Development Coordinate   |                    |  |
|  | _   | de aware of the resident     |                    |                  | or designee, shall observe ent   | teral              |  |
|  | _   | to the emergency room        |                    |                  | feeding tube procedures for at   | t                  |  |
|  | _   | g-tube and she was also      |                    |                  | least 2 residents daily, on scheduled days of work, for 30                             | ,                  |  |
|  | made aware the g                          | g-tube was starting to rip.  |                    |                  | days and monthly there after.  | <b>'</b>           |  |
|  |   |                              |                    |                  | The results will be forwarded t  | 0                  |  |
|  | An Admission or                           | der record dated 2/21/11,    |                    |                  | the performance improvement  | t                  |  |
|  | indicated to flush                        | peg tube with 5 ml           |                    |                  | committee for further evaluation   | on                 |  |
|  | (milliliters) of wa                       | ater before and after each   |                    |                  | or resolution until 100% compliance is achieved.POC                                    |                    |  |
|  | ` ′                                       | to flush peg tube with 30    |                    |                  | date: 3/21/2011  |                    |  |
|  |   | re and after medication      |                    |                  | 33.3. 0.2 1.20 1.  |                    |  |
|  | administration.                           |                              |                    |                  |  |                    |  |
|  |   |                              |                    |                  |  |                    |  |
|  | Review of a hosp                          | pital history and physical   |                    |                  |  |                    |  |
|  | -   | mission of 2/18/11,          |                    |                  |  |                    |  |
|  | indicated a chief                         |                              |                    |                  |  |                    |  |
|  | malfunctioning g                          | •                            |                    |                  |  |                    |  |
|  |   | at illness: The resident     |                    |                  |  |                    |  |
|  | had a g-tube in p                         |                              |                    |                  |  |                    |  |
|  |   | s malfunctioning and this    |                    |                  |  |                    |  |
|  |   | fer to the emergency         |                    |                  |  |                    |  |
|  |   | ing home. The resident       |                    |                  |  |                    |  |
|  | <del>-</del>                              | <del>-</del>                 |                    |                  |  |                    |  |
|  |   | tly by the physician who     |                    |                  |  |                    |  |
|  | took the resident                         | -                            |                    |                  |  |                    |  |
|  |   | dy organs or cavities        |                    |                  |  |                    |  |
|  | -   | be) and replacement of       |                    |                  |  |                    |  |
|  | the g-tube. The c                         | external bumper of the       |                    |                  |  |                    |  |
| FORM CMS 2   | 567(02-99) Previous Versio                | ns Obsolete Event ID:        | <br>G8L511         | Facility l       | ID: 000123 If continuation s   | heet Page 31 of 48 |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |  | (X2) MULTIPLE CO  A. BUILDING  B. WING  | NSTRUCTION          | (X3) DATE<br>COMPI<br>03/03/2   | LETED |                            |
|---|--|---|---------------------|---|-------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF DYER  |  |   | 2300 G              | ADDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311   | •     |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | .D BE | (X5)<br>COMPLETION<br>DATE |
|   | the abdominal wand the old peg to Impression and padmitted with a material burn found to have material burn abdominal wall aremoval and replay was seen post-proposed to the receive antibiotic cover for possible abdominal wall. In the feeds, timely distinguished by the second at 8:00 a.m., indicate the feeds are the feeds at 8:00 a.m., indicate the feeds at 8:00 | and required endoscopic facement. The resident ocedure and had been feeds. The resident will in the short-term to be infection of the life in the short-term to be infection of the life to the tolerates tube charge back to the ticipated.  Administrator on 3/3/11 ficated on 2/1/8/11 the RN complaint on behalf of |                     |   |       |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |  | (X2) MU<br>A. BUIL<br>B. WING   | LDING   | NSTRUCTION          | (X3) DATE:<br>COMPL<br>03/03/2  | ETED |                            |
|---|--|---|---------|---------------------|---|------|----------------------------|
|   | PROVIDER OR SUPPLIER   |   | B. WINC | STREET A            | ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311   | 1    |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN<br>REGULATORY OR<br>to flush the peg t<br>the flush the tube<br>staff nurse to call   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ube and was unable to e. RN#1 instructed the I the Nurse Practitioner   |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΝΈ   | (X5)<br>COMPLETION<br>DATE |
|   | Practitioner instr<br>surgeon who place<br>surgeon was out<br>Practitioner was<br>staff to sent the r<br>room. The night<br>counseled regard<br>Resolution: The  |   |         |                     |   |      |                            |
|   | provided by the a 8:00 a.m. The da 2/18/11 at 5:00 a occurrence invol LPN #2. Event summary/t 2/18/11 at abut 8 to a QMA's attendaughter, that the with her g-tube. tube the RN note occluded and por The night nurse vand the RN took what had happen medications adm | administrator on 3/3/10 at at enter of the incident was an unusual wing Resident #G and appearing on the action by the resident's eresident had a problem Upon assessing the gd that the tube was ached out unnaturally, was still in the facility her aside and asked her ed during the inistration this morning, said that she was busy |         |                     |   |      |                            |

PRINTED: 03/25/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |  | (X2) MULTIPLE CC  A. BUILDING  B. WING  | ONSTRUCTION         | (X3) DATE<br>COMP<br>03/03/2   | LETED |                            |
|---|--|---|---------------------|--|-------|----------------------------|
|   | PROVIDER OR SUPPLIER   |   | STREET A<br>2300 G  | ADDRESS, CITY, STATE, ZIP CODI<br>REAT LAKES DRIVE<br>IN46311  | E     |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETION<br>DATE |
|   | that she dissolve Efforts to clear that and the patient was re-placement." The after careful revisurrounding this pass. The nurse policy on g-tube stated she "cut considered she "cut con | mornings medication admitted to knowing the medication pass and orners" this morning as elmed.  Medication via Feeding ovided by the Director of on 3/3/11 at 8:40 a.m. acluded, but was not ube feeding and diministration set, if cet tube feeding site for: ite, swelling, excoriation mage, or foul odor, check cement (feeding tube esidual check, flush at least 30 ml of warm intraindicated, remove esyringe, attach the eding tube, and pour the |                     |  |       |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |                                   |   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | NSTRUCTION  | (X3) DATE<br>COMPI<br><b>03/03/2</b> | ETED                       |
|---|-----------------------------------|---|--|---|--------------------------------------|----------------------------|
|   | PROVIDER OR SUPPLIER              |   | STREET A<br>2300 G                         | ADDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311   |                                      |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN                    | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE                                 | (X5)<br>COMPLETION<br>DATE |
|   | REGULATORY OR  It was further inc |   |  | CROSS-REFERENCED TO THE APPRODEFICIENCY)  | PRIATE                               | l                          |
|   |                                   |   |  |   |                                      |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |   |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETE 03/03/2011 |                     |  | ETED                                      |                            |
|---|---|---|---|---------------------|--|---|----------------------------|
|   | PROVIDER OR SUPPLIER  |   | B. WIN  | STREET A 2300 G     | ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)                 |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)   | Έ   | (X5)<br>COMPLETION<br>DATE |
| F0315<br>SS=D   | interview the fact 1 of 4 residents in of urinary tract in 14 received the a services to prevent related to a foley contained in a did hold the foley cannot be seen an floor) and lying of #G)  Findings included On 3/3/11 at 7:10 observed in bed where the bed. The foley contained in a dig to the bed. The CNA must be described in the bed. The CNA must be touching the floor was not contained. On 3/3/11 at 8:55 observed in bed where the bed was not contained. | a.m. Resident #G was<br>with her foley catheter<br>mat on the floor by her<br>atheter bag was not | F03   | 15                  | It is the practice of this facility of ensure the highest quality of cis afforded our residents.  Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident G's urinary drainage bag was placed in a dignity bag off the floor during survey. The corrective action taken for those residents having the potential to be affected by same deficient practice is: All residents with foley catheters have the potential to be affected therefore, this plan of correction applies to all residents of the nursing center. The measures into place and systemic chang made to ensure the deficient practice does not recur is:  Licensed nursing staff and C.N.A.'s have been inserviced related to the policy and procedure related to urinary bag placement and the use of dign covers. To ensure the deficient practice does not recur, the monitoring system established A Performance Improvement indicator has been established which evaluates compliance wurinary bag placement and the use of dignity covers. The DNS her representative will complete these indicators monthly for the first quarter and quarterly | are ne ce the ng the ed, n put e ag ity t | 03/21/2011                 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING                             |  |   | (X3) DATE SURVEY<br>COMPLETED |                    |
|--|--|---|---|--|---|-------------------------------|--------------------|
|  |  | 155218  | B. WIN  |  |   | 03/03/2011                    |                    |
| NAME OF F  | PROVIDER OR SUPPLIER   |   | !   | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                    |                               |                    |
|  |  |   |   | 1  | REAT LAKES DRIVE                                  |                               |                    |
|  | REGENCY PLACE OF DYER  |   |   | DYER,  | IN46311   |                               |                    |
| (X4) ID  |  | UMMARY STATEMENT OF DEFICIENCIES  H DEFICIENCY MUST BE PERCEDED BY FULL   |   | ID PROVIDER'S PLAN OF CORRECTION OF CORRECTI |   |                               | (X5)               |
| PREFIX<br>TAG  |  | LSC IDENTIFYING INFORMATION)  | PREFIX (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRI |  | CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | re                            | COMPLETION<br>DATE |
| 1710   |  |   |   | mo   | thereafter with results forwarded                 |                               | DAIL               |
| IAU  | not contained in a On 3/3/11 at 9:45 observed in bed what to bag touching the her bed and the fibag was not cont. The resident's recomplete and the fibag was not cont. The resident's recomplete and the fibag was not cont. The resident's recomplete and to, chronic urinary and the control of the properties of the provided and the chronic urinary.  Interview with R a.m. indicated Recomplete and the chronic urinary a.m., indicated Recomplete and the catheter care Portion of Nursian, indicated the catheter is provided and the collecting-bag between the provided and the collecting-bag between the control of the provided and the collecting-bag between the provided and the collecting-bag between the collecting-bag bag between the collecting-bag bag between the collecting-bag | a dignity bag.  5 a.m. the resident was with her foley catheter mat on the floor beside floor. The foley catheter ained in a dignity bag.  cord was reviewed on m. The resident's ed, but was not limited by tract infection (UTI).  Atted on 6/25/10, indicated isk for complications atheter usage. The floor dead but were not limited bag in a dignity bag for the word of the sident #G did have  N #2 on 3/3/11 at 8:10 esident #G did have  dwelling Urinary flicy provided by the fing on 3/3/11 at 10:20 floor retation." The procedure flimited to, "Position the flow the level of the |   | IAU  |   |                               | DATE               |
|  |  | elow the level of the es. Do not rest the bag   |   |  |   |                               |                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION     |             |        | (X3) DAT  | (X3) DATE SURVEY   |            |
|---|----------------------|--------------------------------|-------------|--------|---|--------------------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER:         | A. BUILDING |        |   | COMPLETED          |            |
|   |                      | 155218                         | B. WING     |        |   | 03/03/2011         |            |
| <b>——</b>   |                      | <u> </u>                       | D. WIN      |        | ADDRESS, CITY, STATE, ZIP COD                               | <b>_</b>           |            |
| NAME OF I   | PROVIDER OR SUPPLIEF | R                              |             | 1      | REAT LAKES DRIVE  | L                  |            |
| REGENIC   | CY PLACE OF DYE      | P                              |             |        | IN46311   |                    |            |
|   |                      |                                |             |        |   |                    |            |
| (X4) ID   |                      | STATEMENT OF DEFICIENCIES      |             | ID     | PROVIDER'S PLAN OF CORRECT                                  |                    | (X5)       |
| PREFIX  | `                    | NCY MUST BE PERCEDED BY FULL   |             | PREFIX | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APP | ILD BE<br>ROPRIATE | COMPLETION |
| TAG   |                      | R LSC IDENTIFYING INFORMATION) |             | TAG    | DEFICIENCY)   |                    | DATE       |
|   | on the floor."       |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   | On 3/3/10 at 1: 4    | 10 p.m. interview with the     |             |        |   |                    |            |
|   | 1                    | sing and Interim Director      |             |        |   |                    |            |
|   | 1                    | as indicated that the foley    |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      | Resident #G was observed       |             |        |   |                    |            |
|   |                      | Director of Nursing            |             |        |   |                    |            |
|   | 1                    | ought to get a dignity bag     |             |        |   |                    |            |
|   | 1                    | ined the dignity bag for       |             |        |   |                    |            |
|   | the resident.        |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   | 3.1-41(a)(2)         |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
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|   |                      |                                |             |        |   |                    |            |
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|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
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|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
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|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |
|   |                      |                                |             |        |   |                    |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | (X2) MULTIPLE CONSTRUCTION   |             |        | (X3) DATE SURVEY  |            |            |
|--|---------------------|------------------------------|-------------|--------|---|------------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER:       | A. BUILDING |        |   | COMPLETED  |            |
|  |                     | 155218                       | B. WIN      |        |   | 03/03/2011 |            |
|  |                     |                              | D. W11V     |        | ADDRESS, CITY, STATE, ZIP CODE  |            |            |
| NAME OF P  | ROVIDER OR SUPPLIER |                              |             | l      | REAT LAKES DRIVE  |            |            |
| REGENC   | Y PLACE OF DYE      | ₹                            |             | l      | IN46311   |            |            |
| (X4) ID  | SUMMARY S           | TATEMENT OF DEFICIENCIES     |             |        | PROVIDER'S PLAN OF CORRECTION   |            | (X5)       |
| PREFIX   | (EACH DEFICIEN      | CY MUST BE PERCEDED BY FULL  |             | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | ΓE         | COMPLETION |
| TAG  | REGULATORY OR       | LSC IDENTIFYING INFORMATION) | <u> </u>    | TAG    | DEFICIENCY)   |            | DATE       |
| F0322  |                     |                              | F03         | 22     | F - 322   |            | 03/21/2011 |
| SS=G   | Based on observa    | ation, interview, and        |             |        |   |            |            |
| 00 0   | record review the   | e facility failed to ensure  |             |        | It is the practice of this facility                                   |            |            |
|  |                     | ment and services were       |             |        | ensure the highest quality of c is afforded our residents.            | are        |            |
|  | provided to 1 of    |                              |             |        | Consistent with this practice, the                                    | he         |            |
|  | •                   |                              |             |        | following has been done: The  |            |            |
|  | _                   | doscopic gastrostomy         |             |        | corrective action taken for the                                       |            |            |
|  |                     | tube used for nutritional    |             |        | residents found to have been  |            |            |
|  | purposes) in a sar  | mple of 14 residents         |             |        | affected by the deficient practi-                                     | ce         |            |
|  | related to the nur  | rse failing flush the        |             |        | was: Resident G's enteral feed  | -          |            |
|  | resident's peg tub  | be prior to administering    |             |        | tube was checked for placeme  | ent        |            |
|  |                     | lting in the peg tube        |             |        | with an air bolus, with proper  |            |            |
|  |                     |                              |             |        | placement verified. The correct                                       |            |            |
|  |                     | ed and the resident being    |             |        | action taken for those resident                                       |            |            |
|  | _                   | al to have the peg tube      |             |        | having the potential to be affect                                     |            |            |
|  | replaced and the    | nurse failing to verify      |             |        | by the same deficient practice  |            |            |
|  | placement and ch    | necking residual prior to    |             |        | All residents of the nursing cer<br>with enteral feeding tubes hav    |            |            |
|  | administering me    | edications. (Resident        |             |        | the potential to be affected,   | 6          |            |
|  | #G).                | `                            |             |        | therefore, this plan of correction                                    | n          |            |
|  | <i>,,,</i> G).      |                              |             |        | applies to all residents with   |            |            |
|  | Findings in deals   |                              |             |        | enteral feeding tubes. The  |            |            |
|  | Findings include    | -                            |             |        | measures put into place and   |            |            |
|  |                     |                              |             |        | systemic change made to ens   |            |            |
|  | 1. The record for   | r Resident #G was            |             |        | the deficient practice does not                                       |            |            |
|  | reviewed on 3/3/    | 11 at 7:35 a.m. The          |             |        | recur is: Licensed nursing staf                                       |            |            |
|  | resident's diagno   | ses included, but was not    |             |        | has been in-serviced related to                                       | )          |            |
|  | _                   | ral vascular accident        |             |        | care of enteral feeding tubes,  | nor        |            |
|  |                     | nd dysphasia (impairment     |             |        | including but not limited to pro technique for checking placem        |            |            |
|  |                     | ій йубрнавіа (ппрапінені     |             |        | and water flushes according to  |            |            |
|  | of speech).         |                              |             |        | physician order. Licensed nur   |            |            |
|  |                     |                              |             |        | will complete a competency  |            |            |
|  | A nursing note da   | ated 2/18/11 at 8:00 a.m.,   |             |        | check off with return   |            |            |
|  | indicated the resi  | ident was in bed asleep,     |             |        | demonstration to ensure prope   | er         |            |
|  | unable to flush g   | -tube (gastrostomy tube,     |             |        | technique.The Staff Developm  | ent        |            |
|  | _                   | ritional purposes). The      |             |        | Coordinator, or designee, shal  | I          |            |
|  |                     | g had clogged the tube.      |             |        | observe enteral feeding tube  |            |            |
|  | _                   |                              |             |        | procedures for at least 2   |            |            |
|  | Several attempts    | were made without            |             |        | residents daily, on scheduled   |            |            |
|  |                     |                              |             |        |   |            |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) M   | (X2) MULTIPLE CONSTRUCTION |               |  | (X3) DATE SURVEY<br>COMPLETED |                 |
|---|--|--|----------------------------|---------------|--|-------------------------------|-----------------|
| AND PLAN  | OF CORRECTION                              | 155218   | A. BUI                     | . BUILDING    |  |                               |                 |
|   |  | 155216   | B. WIN                     |               |  | 03/03/20                      | 11              |
| NAME OF I   | PROVIDER OR SUPPLIER                       |  |                            |               | ADDRESS, CITY, STATE, ZIP CODE                                     |                               |                 |
| DECENC  | CY PLACE OF DYER                           | <b>-</b>   |                            | 1             | REAT LAKES DRIVE<br>IN46311  |                               |                 |
|   | _  |  |                            |               |  |                               |                 |
| (X4) ID   |  | TATEMENT OF DEFICIENCIES                                 |                            | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |                               | (X5)            |
| PREFIX<br>TAG   | · ·  | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |                            | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)                  | re                            | COMPLETION DATE |
| IAU   |  |  | +                          | IAG           | days of work, for 30 days. To                                      | +                             | DATE            |
|   | · ·  | g the tube. Bowel sounds                                 |                            |               | ensure the deficient practice d                                    | oes                           |                 |
|   |  | were present in four abdominal quadrants.                |                            |               | not recur, the monitoring syste                                    |                               |                 |
|   |  | iderness noted. No facial                                |                            |               | established is: A Performance                                      | ance                          |                 |
|   | l -  | time. At 8:30 a.m. the                                   |                            |               | Improvement indicator has been astablished which avaluates         | en                            |                 |
|   |  | er was notified. An order                                |                            |               | established which evaluates compliance with proper technic         | <sub>oue</sub>                |                 |
|   | _  | place feeding on hold and                                |                            |               | for checking placement and wa                                      |                               |                 |
|   |  | ysician who inserted the                                 |                            |               | flushes according to physician                                     |                               |                 |
|   | 1 -  | available appointment                                    |                            |               | order. The SDC, or her design                                      | ee,                           |                 |
|   | 1 .  | n was 2/21/11. The                                       |                            |               | will complete these indicators weekly for at least 2 residents     | for                           |                 |
|   |  | er was notified and an                                   |                            |               | the first quarter and monthly                                      | 101                           |                 |
|   | order was received to send the resident to |  |                            |               | thereafter with results forward                                    | ed                            |                 |
|   | 1  | oom to have a new g-tube                                 |                            |               | to the facility performance  |                               |                 |
|   |  | 0:00 a.m. the resident's                                 |                            |               | improvement committee for  |                               |                 |
|   | daughter was ma                            | de aware of the resident                                 |                            |               | further evaluation or resolution until 100% compliance is          | 1                             |                 |
|   | being transferred                          | to the emergency room                                    |                            |               | achieved. POC date: 3/21/20  | 11                            |                 |
|   | for an occluded g                          | g-tube and she was also                                  |                            |               |  |                               |                 |
|   | made aware the g                           | g-tube was starting to rip.                              |                            |               |  |                               |                 |
|   |  |  |                            |               |  |                               |                 |
|   | Review of a hosp                           | pital history and physical                               |                            |               |  |                               |                 |
|   | with a date of add                         | mission of 2/18/11,                                      |                            |               |  |                               |                 |
|   | indicated a chief                          | complaint of   |                            |               |  |                               |                 |
|   | malfunctioning g                           | g-tube.  |                            |               |  |                               |                 |
|   | History of preser                          | nt illness: The resident                                 |                            |               |  |                               |                 |
|   | had a g-tube in p                          | lace which, on   |                            |               |  |                               |                 |
|   | 1 -  | s malfunctioning and this                                |                            |               |  |                               |                 |
|   | _  | fer to the emergency                                     |                            |               |  |                               |                 |
|   |  | sing home. The resident                                  |                            |               |  |                               |                 |
|   | I -  | tly by the physician who                                 |                            |               |  |                               |                 |
|   | took the resident                          |  |                            |               |  |                               |                 |
|   |  | dy organs or cavities                                    |                            |               |  |                               |                 |
|   | l ` *                                      | be) and replacement of                                   |                            |               |  |                               |                 |
|   | _  | external bumper of the                                   |                            |               |  |                               |                 |
|   | _  | ed to have migrated into                                 |                            |               |  |                               |                 |
|   | peg tabe was not                           | ou to have implaned into                                 |                            |               |  |                               |                 |

PRINTED: 03/25/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |  | (X2) MULTIPLE CC  A. BUILDING  B. WING   | ONSTRUCTION  | COMP  | (X3) DATE SURVEY COMPLETED 03/03/2011 |                            |  |
|---|--|--|--|---|---------------------------------------|----------------------------|--|
|   | PROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  2300 GREAT LAKES DRIVE  DYER, IN46311 |   |                                       |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | .D BE                                 | (X5)<br>COMPLETION<br>DATE |  |
|   | and the old peg to Impression and padmitted with a madmitted was seen post-proposed and replayed was seen post-proposed and replayed and repl | and required endoscopic acement. The resident ocedure and had been feeds. The resident will in the short-term to e infection of the If she tolerates tube charge back to the ticipated.  Administrator on 3/3/11 cated on 2/1/8/11 the RN complaint on behalf of |  |   |                                       |                            |  |

000123

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | A. BUILDING        |                     |  | COMPI | LETED                      |
|---|---|--|--------------------|---------------------|--|-------|----------------------------|
|   |   | 155218   | B. WING 03/03/2011 |                     |  |       |                            |
|   | PROVIDER OR SUPPLIER  |  |                    | 1                   | DDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311   |       |                            |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  |                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
|   | the flush the tube staff nurse to call for update and in Practitioner instructions who place surgeon who place surgeon was out Practitioner was staff to sent the room. The night counseled regard Resolution: The substandard care notified.  Review of a report provided by the answer was staff to a.m. The day occurrence involutely with the substandard care notified.  Review of a report provided by the answer was summary to a construction of the substandard care notified.  Event summary to a construction of the summary to a QMA's attendaughter, that the with her g-tube, tube the RN note occluded and pour the night nurse was and the RN took what had happen medications admit "The night nurse was staff to sent the summary to a QMA's attendaughter, that the with her g-tube. | e. RN#1 instructed the I the Nurse Practitioner structions. The Nurse ucted staff to refer to the ce the peg-tube. The of town. The Nurse informed and instructed esident to the emergency nurse was also ling the incident. nurse was terminated for and public health was endministrator on 3/3/10 at the of the incident was endministrator on 3/3/10 at the of the incident was endministrator on 3/3/10 at the of the incident was endministrator. It was an unusual eving Resident #G and expe of injury: On the endmander to the incident was the endministrator on the endmander of the incident was expected that the tube was uched out unnaturally. Was still in the facility her aside and asked her |                    |                     |  |       |                            |

|                          | NT OF DEFICIENCIES OF CORRECTION  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218   | ENTIFICATION NUMBER: A. BUILDING |  |      | (X3) DATE SURVEY COMPLETED 03/03/2011 |  |
|--------------------------|---|--|----------------------------------|--|------|---------------------------------------|--|
|                          | PROVIDER OR SUPPLIER  |  | 2300 G                           | ADDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311  | •    |                                       |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OR   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | O BE | (X5)<br>COMPLETION<br>DATE            |  |
|                          | Efforts to clear thand the patient water, unless complunger from the syringe to the feeding tube with the DoN on 3/3/11 anurse should have did, there was not suffered to the result of the result. | mornings medication admitted to knowing the medication pass and orners" this morning as elmed.  Medication via Feeding wided by the Director of on 3/3/11 at 8:40 a.m. acluded, but was not abe feeding and diministration set, if ct tube feeding site for: ite, swelling, excoriation mage, or foul odor, check be estimated to the control of the sidual check, flush an at least 30 ml of warm intraindicated, remove syringe, attach the eding tube, and pour the |                                  |  |      |                                       |  |

|                          | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  D PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING   |  | NSTRUCTION | (X3) DATE SURVEY COMPLETED 03/03/2011 |  |    |                            |
|--------------------------|---|--|------------|---------------------------------------|--|----|----------------------------|
|                          | PROVIDER OR SUPPLIER  |  | <u> </u>   | 1                                     | DDRESS, CITY, STATE, ZIP CODE<br>REAT LAKES DRIVE<br>IN46311   | •  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  |            | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ΤE | (X5)<br>COMPLETION<br>DATE |
|                          | terminated and v licensing board.   | vas being reported to the  |            |                                       |  |    |                            |
|                          | observed enterin #G with five men medications. The raised the head of than it was and it what she was go removed her gloo medication cart of and returned. She turned off the feet indicated she need "swish". She dis pump for the peg (milliliter) syring resident abdome approximately 60 syringe and adm gravity. She the stethoscope and the five medicati followed by 30 to  Review of the "M Tube" policy pro Nursing (DoN) of The procedure in limited to, stop to disconnect the acceptance. | 0 cc of water into the inistered the water by n removed her proceeded to administer on. Each medication was to 60 cc of water.  Medication via Feeding ovided by the Director of on 3/3/11 at 8:40 a.m. acluded, but was not |            |                                       |  |    |                            |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | A. BUILDING   |  |                     | COMPL  | ETED    |                            |
|---|--|---|--|---------------------|--|---------|----------------------------|
|   |  | 155218  | B. WIN   |                     |  | 03/03/2 | 011                        |
|   | PROVIDER OR SUPPLIED   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 |                     | REAT LAKES DRIVE   | •       |                            |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI,<br>DEFICIENCY) | ATE     | (X5)<br>COMPLETION<br>DATE |
|   | redness around saround site, draifeeding tube plate placement and refeeding tube with water, unless complunger from the syringe to the femedication into.  The Feeding Tulk Residual Check the Director of Nam. The rations the gastric tube is validate that the and the nasogast auscultation (list tube has not might to another locating This procedure in j-tubes, and n/g G-tubes were to was not limited and/or flush and medications via The procedure in limited to, "for gattach syringe to aspirate stomach." | ite, swelling, excoriation nage, or foul odor, check cement (feeding tube esidual check, flush h at least 30 ml of warm ntraindicated, remove e syringe, attach the eding tube, and pour the the syringe.  The Placement and policy was provided by Jursing on 3/3/11 at 9:50 ale: "The placement of s checked by aspiration to tube is in the stomach ric tube is checked by tening) to validate that the grated or is not misplaced on such as the lungs is appropriate for g-tubes, tubes."  The placement of tube is checked by tening to validate that the grated or is not misplaced on such as the lungs is appropriate for g-tubes, tubes."  The placement of tube is checked included, but too, before each feeding before administering tube.  The placement and pour the eding before administering tube, and gently tubes, are feeding tube, and gently |  |                     |  |         |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218 |  | (X2) MULTIPLE CC  A. BUILDING  B. WING  |  | 03/03/  | (X3) DATE SURVEY COMPLETED 03/03/2011 |                            |  |
|--|--|---|--|---|---------------------------------------|----------------------------|--|
| REGENO   | PROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  2300 GREAT LAKES DRIVE  DYER, IN46311 |   |                                       |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OR  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | .D BE                                 | (X5)<br>COMPLETION<br>DATE |  |
|  | Interview with R manager), on 3/3 indicated prior to initiating a feeding the nurse should bolus, check resing with water  Interview with the DoN on 3/3/11 and nothing to accept the check placement. | the syringe and listening.  N #2 (weekend //11 at 11:15 a.m., o using a peg for a negor giving medications auscultate with an air dual, and flush the tube  The DoN and the Interiment 1:40 p.m., indicated she aid if the LPN did not prior to administering the peg tube for Resident #G. |  |   |                                       |                            |  |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155218 03/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2300 GREAT LAKES DRIVE REGENCY PLACE OF DYER DYER. IN46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0505 Based on record review and interviews, F0505 03/21/2011 F - 505the facility failed to ensure the resident's SS=D It is the practice of this facility to physician was promptly notified of ensure the highest quality of care laboratory results related to an urinalysis is afforded our residents. Consistent with this practice, the and culture and sensitivity for 1 of 14 following has been done: The sampled residents. (Resident #L) corrective action taken for the residents found to have been Findings include: affected by the deficient practice was: The physician was notified of the delay in treatment with no The record for Resident #L was reviewed new orders being received. The on 3/2/11 at 1:15 p.m. An urinalysis was corrective action taken for those collected for the resident on 2/22/11 with residents having the potential to the final culture results reported back to be affected by the same deficient practice is: All residents have the the facility on 2/24/11 at 11:32 a.m. The potential to be affected, therefore, final culture results indicated "Probable this plan of correction applies to skin flora contamination, collect a new all residents of the nursing center. specimen if clinically indicated." The measures put into place and systemic change made to ensure the deficient practice does not Review of Physician orders dated 2/26/11 recur is: Licensed nursing staff indicated to straight cath for a urinalysis. has been in-serviced relative to Review of Nurses Notes dated 2/27/11 appropriate and timely follow up related to obtaining and follow up indicated "Straight cath performed urine related to laboratory results. cloudy, yellow with visible sediment, Labs will be reviewed during strong odor present." Monday through Friday clinical meetings to assure prompt follow-up and results. To ensure Review of Nurses Notes dated 2/24 and the deficient practice does not 2/25/11 indicated there was no recur, the monitoring system documentation the resident's physician established is: A Performance had been notified of the need to get Improvement indicator has been established which evaluates another urine sample. compliance with obtaining and follow up on laboratory results to Interview with the South Unit Manager on include timliness. The DNS, or 3/3/11 at 9:00 a.m., indicated there was a her designee, will complete these

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G8L511

Facility ID:

000123

If continuation sheet

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218 |                      | A. BUILDING B. WING   | UNSTRUCTION         | COMPLETED 03/03/2011   |                       |       |
|---|----------------------|---|---------------------|--|-----------------------|-------|
|   | PROVIDER OR SUPPLIER |   | STREET 2300 G       | ADDRESS, CITY, STATE, ZIP CODE<br>GREAT LAKES DRIVE<br>IN46311   | 1                     |       |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | (XS<br>COMPLE<br>DATI | ETION |
| TAG   | •                    | g the resident's physician  | TAG                 | indicators weekly for at least residents for the first quarter monthly thereafter with result forwarded to the facility performance improvement committee for further evaluat or resolution until 100% compliance is achieved. POC date: 3/21/2011 | 2<br>and<br>s         |       |